

of the canal. (4) Where omentum is found in a hernia, it should be securely tied and resected. (5) The wound in the region of the external ring should be healed by granulation to afford a cicatricial barrier, as an additional factor in the cure.—*N. Y. Med. Rec.*, March 5, 1887.

**V. Hernia Inguino-Peritonæalis.** By CHARLES W. DULLES, M.D. (Philadelphia). The author describes a case of strangulated hernia, which he believes to have been a case of properitoneal hernia, but his description is unfortunately so deficient in diagnostic points that the reader is unable to discover upon what he founds his diagnosis. While remarking the fact that very little attention has been paid to the subject in this country, he fails to define the condition so that the reader not familiar with the subject can understand it—the nearest approach to a definition being that properitoneal, while not fully descriptive, may be employed to describe hernias occupying unusual positions within the abdominal or pelvic wall in front of the peritoneum. The paper is valuable, however, for a résumé of thirty-three cases of the lesion.—*Med. News*, Jan. 22, 1887.

## EXTREMITIES.

**I. Operative Shortening of the Bones of the Leg in the Treatment of Injuries Complicated with Extensive Destruction of Soft Parts.** By WILLIAM D. HAMILTON, M.D. (Columbus, Ohio). After discussing the abstract on this subject presented in the *ANNALS OF SURGERY*, vol. iii, p. 525, without giving proper credit, however, the author relates the case of a girl, æt. 10, whose left leg was almost cut in two at the junction of the lower and middle third, the lower fragment being bent at right angles to the upper one; an irregularly rectangular lacerated wound,  $2\frac{1}{2}$  inches broad in the continuity of the leg and five inches long had been inflicted; in this area the soft parts were extensively destroyed to the level of the deeper posterior layer of muscles, both bones were comminuted in their whole diameter, and the periosteum was denuded from the upper tibia for three-quarters of an inch—nearly everything lying in front of a plane passing posterior to both bones being destroyed for two and a

half inches in the continuity of the leg. After checking the quite profuse hæmorrhage by tying the divided ends of the anterior tibial artery with catgut, the periosteum was well retracted, a transverse even division of the bones made above and below the injury, the intervening fragments comprising about two inches of both fibula and tibia dislodged, and neat apposition secured without wiring or suturing. The wound was closed and dressed antiseptically, and splints applied to secure immobility. Recovery was complete three months later with a little less than two inches shortening. The operation had two things in view: 1. To prevent gangrene and save the limb by inducing prompt union throughout, the idea being to remove the bone which occupied the gap and which, being the focus of inflammation, and suppuration, threatened the posterior blood and nerve supply; 2, or to anticipate a probable long siege of periostitis, osteitis, necrosis or osteo-myelitis. For several months the temperature of the limb was lowered and it had a dusky hue, its nutrition and innervation being seriously impaired by the complete division of the anterior vessels and nerves. Unlike the operation of Martel, this was a primary operation.—*Jour. Am. Med. Ass'n.*, Jan. 22, 1887.

**II. Subperitoneal Amputation at the Hip-joint after Hip Disease.** By EDWARD H. BRADFORD, M. D. (Boston, Mass.). This paper contains a table of 22 amputations at the hip-joint for hip disease, to supplement that given by Ashhurst in the International Encyclopædia of Surgery, showing a mortality of only 14 per cent. since 1880. A case is detailed in which the author performed the operation with a perfect result. As Lisfranc's method of disarticulation is not readily done if an elastic tourniquet is used, he recommends a method which is practically that of Furneaux Jordan. A lateral incision is made as in excision of the head of the femur, the head of the femur is excised in order that it be out of the way, the lateral incision is prolonged and the shaft of the femur separated for two or three inches in its length from the surrounding muscles, taking care that the periosteum remains with the muscles; a circular amputation of the thigh is then done, the bone sawn through, or if entirely freed from the sur-

rounding tissues by the lateral incision, pulled out from the flaps without sawing; then the vessels are tied and the tourniquet removed. He concludes: (1). Amputation at the hip-joint in hip disease should be regarded as the very last resort, contraindicated by extensive amyloid degeneration of the viscera or a moribund condition of the patient. (2). The chances of mortality are not greater than the chances given in amputation of the thigh in general. (3). The chances of a permanent cure (barring the mutilation) would appear to be greater than after excision at the hip-joint. (4). The amputation should be done subperiosteally whenever possible. An elastic tourniquet gives the best means of preventing hæmorrhage. (5). Preliminary excision of the head of the femur, in freeing the upper part of the shaft, will be found to facilitate the amputation.—*Boston Med. and Surg. Jour.*, February 24, 1887.

III. The Osteoplastic Resection of the Foot of Wladimirow and Miculicz. By CHRISTIAN FENGER, M. D. (Chicago). This operation has already been described in the *ANNALS OF SURGERY*, Vol. iii, p. 425, and Vol. v, p. 161. This paper gives a complete historical sketch of the operation, a full description of the operative details, its indications, after-treatment and results, with a table of the eighteen cases reported previous to the writing of the paper and a full report of a new case by the author. A man, æt. 28, had been suffering from chronic traumatic myelitis for ten years, which had produced ankylosis of the joints from the ankle to Chopart's articulation. There were fistulas leading to suppurating bone in the sinus tarsi, and an ulcerating cicatrix appeared on the posterior and lower surface of the heel. Evidence upon two occasions had been followed by relapse. The Wladimirow-Miculicz operation was then performed. Healing was definite in four months. The toes being fixed in semi-flexion were two months later forcibly extended, which resulted in rupture of the skin beneath the first and second metatarso-phalangeal joints, from which an ulcerating cicatrix sprang; this was finally cured by excision of the cicatrix and transplantation of a flap from the sole of the foot. Fifteen months after the operation the patient could walk with boot.

and cane, and bear the whole weight on the foot; the ankylosis was solid. There was five centimetres of lengthening of the lower extremity on that side. The author concludes: 1. The osteoplastic resection of the foot, as devised by Wladimirow and Miculicz, has a legitimate place in the surgery of the foot. It gives functional results superior to those of the supramalleolar amputation. 2. Destruction of the soft parts of the heel is an indisputable indication for its performance. 3. In tuberculosis of the ankle joint with tarsus atypical excisions may be done, as advised by Connor and Kappeler, or Pirogoff's or Syme's operations. It is doubtful whether these operations, in cases permitting the choice, should be abandoned in favor of the osteoplastic resection. This question can be answered only after further observations have been made as to the permanent cure of the disease by the operation, the duration of its after-treatment and its final functional results. 4. The results so far recorded allow of a choice between the osteoplastic resection and the operations mentioned, for the purpose of determining its value as compared with that of older operations.—*Jour. Am. Med. Ass'n.*, January 29, 1887.

#### GENITO-URINARY ORGANS.

I. Six Cases of Suprapubic Lithotomy. By Dr. C. M. THOMAS (Philadelphia). CASE I. Male, æt. 67 years. Large, sacculated stone. Preliminary distention of bladder only. Stone dislodged with some difficulty from behind and to the left of the prostate, weight three ounces; soft catheter left *à demeure*; rubber drain through wound; wound granulated slowly, leaving a fine fistula which did not close till lapse of several months.

CASE II. Male, æt. 66 years. Preliminary rectal and vesical distention; stone of five drams' weight removed; suture to bladder wound and to superficial wound; inlying catheter; urine appeared at wound in thirty-six hours, when all superficial stitches were removed; urine ceased to appear after ten days; healing complete in five weeks.

CASE III. Male, æt. 47 years. Deep perineal sinuses and fistulæ. Preliminary rectal and vesical distention. Stone of 200 grains' weight. Suture to bladder wound. Flow of clear, odorless fluid from